LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

1.15 pm – 1.45 pm, Friday, 19 June 2015

Litchfield Room, Level 3, Parliament House

Members:	Mr Nathan Barrett, MLA, Chair, Member for Blain Ms Lauren Moss, MLA, Deputy Chair, Member for Casuarina Mr Gerry Wood, MLA, Member for Nelson
Apologies:	Mr Francis Kurrupuwu, MLA, Member for Arafura
Witnesses:	**NT AIDS and Hepatitis Council** Kim Gates: Executive Director

Mr CHAIR: On behalf of the committee I welcome you to this public hearing into the prevalence, impacts and government response to the illicit use of ice in the Northern Territory. I welcome to the table to give evidence to the committee from the NT AIDS and Hepatitis Council, Kim Gates, Executive Director.

Thank you for coming before the committee. We appreciate you taking the time to speak to the committee and look forward to hearing from you today. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. This is a public hearing and is being webcast through the Assembly's website. A transcript will be made available for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public you may ask that the committee go into a closed session and take your evidence in private.

I will ask you to state your name for the record and the capacity in which you appear. I will then ask if you would like to make an opening statement before proceeding to the committee's questions.

Could I please get you to state your name and the capacity in which you are appearing.

Ms GATES: My name is Kim Gates and I am the Executive Director of the NT AIDS and Hepatitis Council. I am representing people who inject drugs, their views and their rights.

Mr CHAIR: Thank you. Would you like to make an opening statement?

Ms GATES: Yes. The perspectives I am putting forward today are both of people who inject drugs who come into contact with our service, our staff, which is a peer-based service delivery model, and our board and our members.

We do not believe that ice usage is problematic for all people. There is no evidence to support the assertions that the NT is experiencing an epidemic. We understand that a certain percentage of people who use ice become psychotic or can become violent, but that, in the main, is quite a small number.
We operate from a harm reduction perspective. Under the National Drug Strategy harm reduction is one of the three major pillars. The services that we deliver are from a harm reduction approach, including needle syringe programs for people who inject drugs. That is where we have our day to day contact with that population.

We operate from a peer service delivery model, we employ peers to work with their peers because that is the best way to engage the population into health services rather than expect them to enter into mainstream services where they might feel marginalised.

Law enforcement is not the answer. I believe the hysteria around ice has been created by the media. A lot of the most recent articles in the newspapers, not just in the NT but Australia-wide, have been unsupported. There was a recent article about a man digging out his eyeballs and eating them – definitely incorrect. That hysteria has created a fear within the community and not only the general community, but drug treatment services and the like, that makes people feel they cannot deal with this issue and I do not believe that is correct. Most people that are trained in drug and alcohol, which I am, can deal with this issue because it is a substance and, like any other drug, has associated issues that can be addressed through treatment or counselling services. I do not believe it needs a separate response in that sense.

The other point I wanted to express, which is reflected in our submission, is that we certainly would like a health-based appropriately-resourced response which is grounded in a harm reduction framework because we will never stop people using drugs. That is the reality. There will always be a certain population that continues to use drugs, and we want to ensure they do that safely so the other harms associated with drug use are addressed.

Mr CHAIR: You made some really interesting statements and ones I have heard from other people, mostly on the quiet, and not what they would say in front of a committee. Your first point, that occasional ice use is not considered to be habit forming, I heard from somebody who was an occasional user. He would see that as the case with the group of people he was associating with at the time. Do you have any studies or any evidence to suggest that is the case? Obviously many people have come before you, and probably many will come after you, who will tell this committee the exact opposite and cite the A, B, C, D, E and F for that.

Ms GATES: Yes, exactly.

Mr CHAIR: You are really contrary and I would like to know …

Ms GATES: There are no studies in the Northern Territory. I know some preliminary studies have been undertaken in other jurisdictions, particularly around gay men and men who have sex with men, because there are pockets of populations where ice use is sporadic and mainly used for increasing sexual pleasure, and that is one population that occurs in. The other possible group is sex workers. However, there is not a lot of evidence and it is mostly anecdotal.

From my knowledge and from talking to other AIDS Councils around the country, experiences are that some gay men or men who have sex with men will use ice recreationally around a sex party or an event rather than it be consistent use, and therefore it is not problematic. Obviously, with any drug long-term or habitual use will form addictive behaviours, but you can use alcohol responsibly, and I gather you can use ice responsibly in that sense.

Mr CHAIR: That is very contrary. There would be many people …

Ms GATES: Obviously, to become addicted to a substance it is long-term or habitual use. If you are not doing that you are not forming an addiction.

Mr WOOD: Is it not an addictive drug?

Ms GATES: I have no knowledge of whether it is or not. Obviously some people are saying it is. I know lots of people who use ice and none of them are addicted.

Mr WOOD: In relation to your role, it is basically to give people needles and syringes if needed to reduce the risk of HIV.

Ms GATES: HIV and other blood-borne viruses.

Mr WOOD: Yes, that is right.

Ms GATES: Hepatitis C and B.

Mr WOOD: What is the most common method of injecting ice? Are you there to just help people enjoy what they think is their lifestyle or do you have a program saying you do not think it is a good lifestyle. You are not forcing it on them because that is not your job, but is there an educational side asking why people are taking these mind blowing substances and should they think about their health and try to move away from that?

Ms GATES: There were several questions there and I think I have lost the first one. In relation to the second one, we are responding to blood-borne viruses and the other health-related harms that come from injecting drugs. We only see people who inject drugs because they come in to collect needles.

Mr WOOD: Are they injecting ice?

Ms GATES: About 40% of the people who walk through our doors state that ice was their last drug of use, which is the information we collect. That is not to say they do not use other drugs - that was their last use. The lack of data is quite problematic. There is no data, even within our service, that is really concrete and can tell you how far this issue goes.

The second part of the question is we have a harm reduction approach around the blood-borne viruses. We work very closely with the Alcohol and Other Drugs program at RDH, Block 4. When people find their drug use might be problematic and they want help we can make referrals into programs there, which are maintenance programs, which is not really for ice but the methadone replacement program, for example, or we can make referrals into the drug and alcohol treatment services which we also work quite closely with.

Mr WOOD: Is that only if they ask for it?

Ms GATES: We provide education about the harms of drug use. We are not funded to do alcohol and other drug work; we are there to provide the needle/syringe program. We do not, as you said, force it down people's throat. The information is there, it is available in our NSPs for people to see and read. We send messages around the harms of drug use all the time through our health promotion messaging, but we do not stand there saying, 'You should get help'.

Ms MOSS: Thank you for coming before us today. You mentioned that often use of ice might be part of a number of drugs that somebody might be using. Is there a mix of drugs that you see ice commonly used with?

Ms GATES: Not to my knowledge. In the NSP the three main drugs reported as last use are opiates, ice or steroids, steroids being the highest percentage. We are seeing far more of an increase in use of steroids in the Northern Territory than ice. We have seen no increase in the number of people walking through in the NSP. What we are seeing anecdotally is the drug is becoming more pure, and that is why it is becoming more problematic, but the numbers of people we are seeing in our NSP is not increasing.

What we are seeing - again it is anecdotal - is younger people coming in. Younger people see it now as their first choice. When they first want to experiment with drugs ice is their first drug of choice.

Ms MOSS: Do you have a view on why that might be?

Ms GATES: I think it is about the euphoria the drug gives you when you take it. I think for people when they first use ice, before it comes problematic, it is such a nice sensation. People talk about that and make it sound like a good thing to do. I guess like anything with peers, if your friends are doing something that seems really good you will jump on board and try it as well.

Ms MOSS: In your NSP, I do not know if we have stated it for the record, but it is the needle and syringe program. Is there any evidence that the needle and syringe programs are required outside major urban and regional centres in the Territory?

Ms GATES: We have seen some sporadic use of injecting in remote communities. It is small numbers, but as far as I am concerned even one is too many because of the other harms that can come from injecting. In remote communities we have people who are not experienced and that may result in other harms such as vein damage from not being experienced in injecting. The fact that they will not access health services for any damage for fear of being - is a concern for us. Where we have seen evidence of it happening in remote communities it has been related to resources. It is around mine sites or where there is FIFO activity or construction. We have definitely seen drugs are often used in transactional sex.

Ms MOSS: We have heard that today.

Mr CHAIR: I am very interested in what you have said today because everybody else who has spoken to us deals with people who tend to be on the dependent end. They are drug-dependent people, and they are expressing various traumatic behaviours which are causing problems which affect the community. We are working on strategies to stop that. That is a small percentage of the number of people who are using the drug, to my knowledge. The information you bring to this committee is pertinent because it addresses people who are not dependent. I would like to fire some things off to you because we are not getting a lot of data about non-dependence and you might have more data on that.

You say 40% of people using your services - how many people are we talking about?

Ms GATES: Again, data can be interpreted in any way. In the last 12 months it was 3088 episodes. That could be one person 3000 times, but that is not likely. The exact number of people we do not have. We only have the number of times someone has walked through the door and said they use methamphetamine.

Mr CHAIR: What does your instinct tell you about how many people are using …

Ms GATES: Again it is very difficult to say because those people might be collecting equipment for other people as well. We have people who come in every week and collect regularly. I would say probably half you could say are real people, so around 1500.

Mr CHAIR: So 1500 people come in and 40% of them say the last thing they used was ice. Generally these people are …

Ms GATES: No, those 1500 are ice. The 3088 episodes are only 42%. We get about 10 000 people through our door every year.

Mr CHAIR: That is great information. So 1500 people …

Mr WOOD: That is 10 000 episodes.

Ms GATES: Ten thousand episodes, yes. This is where data gets very easy to manipulate. We have about 10 000 episodes of service. Of those, 3088 are for methamphetamine

Mr CHAIR: We have limited time but it is on the record and we can read it. Generally, are the majority of these people non-dependent?

Ms GATES: Many of them are not, yes.

Mr CHAIR: Can you give us a snapshot on the type of people? Are they across a broad spectrum? Are they Indigenous or non-Indigenous? Are they white collar workers or blue collar workers? Can you give us a snapshot of who they are?

Ms GATES: I can give you a small snapshot. Across the three NSPs, which is Alice Springs, Palmerston and Darwin, 20% of our clients are Aboriginal. In Darwin we see more workers from mines, FIFO, because of the steroid use as well. We see a lot of crossover with steroid users and methamphetamine users as well. In Alice Springs and Palmerston – Alice Springs is probably more Aboriginal - the percentage is probably higher in Alice Springs than here. In Palmerston more unemployed, low socioeconomic background type.

Mr CHAIR: These people are saying, 'I'm not addicted to this drug. I just have fun.' Are you dealing with addicts?

Ms GATES: We see people who obviously have problems with it. We have never had any episodes of violence or psychosis in our service at all, but we see people come in who are at the point where they are at problematic use.

Mr CHAIR: What could we do to help? You do this but you are not encouraging people to take drugs. I assume there is a pretty strong mandate in your entity that you quietly try to stop people taking drugs? Do you judge at all?

Ms GATES: We have a no judgment policy. Ours is a health-based approach about blood-borne viruses and to reduce the harms related to drug use. If we started judging people who walk through our doors they would stop walking through our doors.

Mr CHAIR: I get that, but we are trying to figure out ways to impact the demand on this drug. In your time there have you thought this particular drug - if this or this was in place we would see less frequency of …

Ms GATES: The person before me talked about prevention. I think prevention is a really good start, but I think there needs to be more harm reduction strategies …

Mr CHAIR: By prevention - those words mean a thousand things. What do you mean?

Ms GATES: I am not really into the prevention end of things, but I imagine education campaigns and getting to young people in schools and talking about the associated harms. I do not think our school curriculum around drug use is very good. I believe the Victorian model is a good example. I have not seen it personally, but I hear from other jurisdictions it is the one everyone puts on a pedestal. It may be something this committee wants to look at. From a harm reduction perspective, there are certainly lots of strategies, not only services like the needle syringe program, but things like stimulant check clinics.

Most people who inject drugs will not engage in mainstream health services for fear of their drug use being identified. If you have user-friendly services like ours, where they might access a health professional to check on their health …

Mr CHAIR: This is why you talking about community based …

Ms GATES: …and you might be able to make those interventions before their drug use becomes problematic. Some community groups at the moment - little ice support groups are springing up. There is one in Darwin and one in Alice Springs. They are mainly parents and family concerned about their young people and their drug use. Some resourcing of those could be really good, but as long as drug users are not demonised. While drug users are being demonised rather than the drug, they will never access services.

Ms MOSS: That segues nicely into the questions I have. I understand where you are coming from in regard to the scope of your service. If somebody identifies as wanting to modify their drug use, are they referred on to other services? What does that look like currently? Do you see there could be a strengthened promotion of information services? I am interested in your views on that.

Ms GATES: We work quite closely – I see one of the services is in the room now – with a lot of the treatment services around the Territory. Within the alcohol and other drugs sector there is a fairly strong knowledge of what is out there and where we can refer people. Where it becomes problematic is beds being available in residential services, and also other treatment options for people who do not necessarily want to enter into residential treatment - people who might have children. There are some issues around whether those services best match their needs. There could be some work around treatment options and treatment matching for clients.

Ms MOSS: We have talked about families seeking help and have heard there are cases where people are unsure where to go if they are concerned about methamphetamine use - where to see treatment and get advice. Have you seen any increase in inquiries as a result of the ice campaigns happening on a local and national level?

Ms GATES: No, not to our service. The talk we hear about the campaign is nobody likes it.

Ms MOSS: I would be interested in the feedback you get about those campaigns.

Ms GATES: The campaign, as a scare tactic – I do not believe scare tactics work in campaigns, in health promotion campaigns anyway, but around the country the feedback on the campaign is it is being compared to the Grim Reaper campaign, and although everyone remembers it the Grim Reaper campaign did nothing to reduce HIV in the community at that point in time. It is a campaign people will remember, but will it make a difference? Probably not. It is not encouraging people to access treatment.

Mr WOOD: Getting back to some of your statistics, you said some people are not addicted to ice but if people are coming in every week would that not be a sign that they are addicted?

Ms GATES: That is what I am saying. We see some people who are problematic, and when they come in our staff would ask them what is happening in their lives and if they need referrals to health services or whatever. As I said, we cannot force people to engage in services if they do not wish to.

Mr WOOD: I am not trying to be smart, but you said at the beginning you could say how many episodes and that 20% of people were Indigenous. You had to get that 20% from numbers, you could not get it from episodes. How do you come to …

Ms GATES: That is based on episode numbers. We ask the same set of questions to everyone who walks in and Aboriginality is one of the questions. About 20% of those episodes are Aboriginal people.

Mr WOOD: That is what I wanted to clarify because they are two different things.

Ms GATES: There are lots of holes in the data and we recognise that, but it is probably the best data we could provide around who is using because that is where the big gaps are. We know, as you said, the people at the pointy end who are accessing treatments at critical points, but it is a low number compared to the number of people not accessing services.

Mr CHAIR: You guys do needle and syringe exchanges. In regard to ice, is injecting a common way of taking ice or are most people smoking it?

Ms GATES: I think smoking is the initial way people start use ice. It is easy and quick, and easy to get it into your system. I think the progression to injecting with any drug is more about getting the kick or the thrill quicker. Your source of taking the drug can change for any drug. I have no specific knowledge of how many people are smoking; we can only talk about people who inject drugs.
I went to an ice support group and a young Aboriginal man there talked to me about his use. He said of his cohort of friends, 40% were 'bangers'. That means that they are injecting - they are banging, injecting.

Mr CHAIR: The people saying to you the last drug they used was ice, are they generally injecting?

Ms GATES: Yes, they are injecting.

Mr CHAIR: In your submission you recommend trialling needle and syringe vending machines. To what extent are needle and syringe vending machines used in other jurisdictions? How do you see this helping us stop people taking ice?

Ms GATES: At the moment in the Northern Territory needles and syringes are not available 24 hours. They are only available from our service or from some pharmacies or Clinic 34, which all operate during business hours. The idea of an expansion of the NSPs is really about reducing the harms that come from sharing needles, which is around blood-borne viruses and other injecting-related harms. It is just an expansion of the work we are doing.

They have vending machines in nearly every other jurisdiction in the country. Our current legislation does not allow us to have vending machines so we are aware, particularly now with this ice support group that we have been going to, that there is a cohort of young Aboriginal people who did not even know about needle syringe programs. They have been buying or getting syringes from other sources and sharing and putting themselves at greater risk because of that. That is why we put that argument forward.

Mr CHAIR: Are there any other issues you would like to raise with the committee?

Ms GATES: I think there needs to be an end to some of the inaccurate language and hysteria that happens in the media because it instils a greater fear in the community and

Mr CHAIR: I think it was your one spoke about how you wish that the media was more accurate and what was the other word?

Ms MOSS: More reporting.

Mr CHAIR: And sensitive, and in my line of work I share that sentiment.

Ms GATES: In the HIV sector, for example, there is a media guide which goes out to the media. It is available online. It talks about how they can report on HIV sensitively. Obviously. that is very debilitating illness and it sometimes can be inappropriately reported in the press. A guide like that would be quite beneficial.

Mr CHAIR: Wonderful. Thank you for your time.